



King's Research Portal

DOI:

[10.1080/13607860903586144](https://doi.org/10.1080/13607860903586144)

Document Version

Peer reviewed version

[Link to publication record in King's Research Portal](#)

Citation for published version (APA):

Lawrence, V., & Banerjee, S. (2010). Improving care in care homes: A qualitative evaluation of the Croydon care home support team. *Aging and Mental Health*, 14(4), 416 - 424. <https://doi.org/10.1080/13607860903586144>

Citing this paper

Please note that where the full-text provided on King's Research Portal is the Author Accepted Manuscript or Post-Print version this may differ from the final Published version. If citing, it is advised that you check and use the publisher's definitive version for pagination, volume/issue, and date of publication details. And where the final published version is provided on the Research Portal, if citing you are again advised to check the publisher's website for any subsequent corrections.

General rights

Copyright and moral rights for the publications made accessible in the Research Portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognize and abide by the legal requirements associated with these rights.

- Users may download and print one copy of any publication from the Research Portal for the purpose of private study or research.
- You may not further distribute the material or use it for any profit-making activity or commercial gain
- You may freely distribute the URL identifying the publication in the Research Portal

Take down policy

If you believe that this document breaches copyright please contact librarypure@kcl.ac.uk providing details, and we will remove access to the work immediately and investigate your claim.

Improving care in care homes: a qualitative evaluation of the Croydon Care Home Support Team

Aging and Mental Health

Objectives: The Croydon Care Home Support Team (CHST) was developed in response to reports of patient abuse within long term care. It presents a novel strategy for improving standards of care within care homes. A qualitative methodology was used to assess the perceived impact of the CHST.

Method: In-depth interviews were conducted with 14 care home managers and 24 members of care home staff across 14 care homes. Grounded theory principals guided the collection and analysis of the data.

Results: Reports of improved communication between staff, improved staff development and confidence, and improved quality of care point towards the effectiveness of the CHST model. The collaborative approach of the CHST was considered pivotal to its success and presented as an effective method of engaging care home managers and staff. The CHST adopted a systemic approach that placed an equal emphasis on the social, mental health and nursing needs of residents and aimed to address the whole culture of care within the individual homes.

Conclusions: The data demonstrate the potential for specialist multi-disciplinary teams to raise standards of care across long term care settings. Increased awareness of safeguarding issues, improved staff morale and communication, and ongoing opportunities for discussion and problem solving promised to sustain improvements. Such services could be instrumental in meeting the government priority of preventing abuse among vulnerable adults.

Keywords: Institutional Care, Training and Education, Abuse / Neglect

Improving care in care homes: a qualitative evaluation of the Croydon Care Home Support Team

Introduction

The total number of older people living in long term care, and the challenges that this poses to service providers and care homes staff, can be expected to rise as the population ages (Bajekal, 2002). The independent sector now provides approximately 90% of the long stay care homes in England (Department of Health, 2000b) and the prevalence of residents with dementia and physical disability has increased in an unplanned way (Bowham, Whistler, & Ellerby, 2004). However, care staff often receive minimal training in caring for individuals with complex needs (Proctor et al., 1999) and there is evidence that physical and mental health care needs can be poorly managed in this setting (Bowham et al., 2004; Hancock, Woods, Challis, & Orrell, 2006). Many people with dementia do not receive the specialist level of care that they require and research indicates the inappropriate use of psychotropic drugs among this population (Ballard et al., 2001). It is argued that poor care standards and rigid institutional regimes contribute to a poor quality of life among care home residents (Ronch, 2004).

The growing recognition of the need for quality improvement exists alongside an increased emphasis on regulation and quality assurance in long term care (Kerrison & Pollock, 2001). Surveys of professional carers have reported that 16% of staff in long-term care facilities have completed acts of significant psychological abuse (Wang, 2006), while 10% admit to physical abuse including the use of excessive restraints, pinching, shoving, grabbing and hitting (Pillemer & Moore, 1989). Cooper et al. (2008) reflect that this may underestimate the true prevalence of abuse given that 80% of care home staff

report witnessing abusive behaviour. *No Secrets* (Department of Health, 2000a), the government guidance for protecting vulnerable adults from abuse in England, states that abuse can occur in different forms including physical, sexual, psychological and financial abuses, discrimination and neglect. Elder abuse of all types can have profound negative consequences and there is evidence of increased mortality rates among older adults that have suffered mistreatment (Lachs, Williams, O'Brien, Pillemer, & Charison, 1998).

In recent years attention has shifted away from an exclusive focus on the 'bad apple' model of abuse, which conceptualises perpetrators as a minority group of malicious individuals that misuse their power, and begun to explore the situational characteristics that place individuals at risk (White, Holland, Marsland, & Oakes, 2003). Pillemer and Bachmann-Prehn (1991) identified feelings of burnout and conflict between staff as the most important predictors of abuse. Poor training, low salaries, low morale and staff shortages have also been identified as contributing factors (Wierucka & Goodridge, 1996). White (2003) discussed the importance of staff attitudes in the abuse of people with intellectual disabilities, suggesting that a process of dehumanisation, whereby people with learning disabilities are seen to have minimal rights and values, can lead to unacceptable behaviour. The competence of managers was also considered paramount, as supervision, a culture of accountability and an ability to challenge abusive practices, can reduce vulnerability and risk. Patient abuse within care homes has long been a neglected topic (Payne & Fletcher, 2005) and research is needed to examine the effectiveness of preventive strategies. What is clear is that there are diverse and complex causes of abuse that demand a multifaceted response.

Statutory service providers and commissions of long-term care services in the UK have begun to respond to the challenge of enhancing the quality of care for residents and their families. Hayes (2004) described the development of a care home support team, structured around older person's specialist nurses, which managed the interface between nursing homes and primary care. Specialist nursing in-reach teams have also been developed to improve clinical care in care homes (Anderson, 2004; Szczepura, Nelson, & Wild, 2008), yet there is little evidence documenting the effectiveness of these interventions (Doherty, 2008). Research does suggest that brief mental health training (Lyne et al., 2006; Proctor et al., 1999) , training in communication (McCallion, Toseland, Lacey & Banks, 1999) and staff behavioural management skills (Burgio, et al., 2002) can enable positive changes for residents in long term care. However, a recent review of nursing home training in dementia care identified methodological weaknesses and a paucity of strong evidence in intervention studies (Kuske et al., 2007). Qualitative research examining attitudes and beliefs of care home staff surrounding interventions holds the promise of advancing our understanding of what does and does not work to improve quality of care. We present such an evaluation here.

The Croydon Care Home Support Team (CHST)

The CHST is a joint initiative between the Croydon NHS Primary Care Trust, Croydon Council and South London & Maudsley NHS Foundation Trust. Croydon is the largest borough in London with approximately 42,000 adults over the age of 65. There are 27 care homes with nursing (i.e. traditionally known as 'nursing homes') and 140 care homes without nursing (i.e. traditionally known as 'residential homes') registered with the Care Quality Commission within the local authority area. The CHST was developed in

response to concerns about the number of reported safeguarding incidents, i.e. reports of abuse of vulnerable adults. The team has three core objectives:

1. To improve the quality of care provided within care homes in Croydon.
2. To enable staff in care homes to sustain improved quality of care.
3. To prevent safeguarding issues.

The CHST initially worked with care homes as part of the safeguarding action plan. However, self-referrals were subsequently encouraged and the team works with a number of care homes on a voluntary basis. The team agreed to the use of its full name in this publication. The service provided by the CHST will now be described.

The CHST model

The CHST is a small focussed multi-disciplinary team comprising one district nurse, one community psychiatric nurse and one social worker. The remit of the CHST is deliberately wide and encompasses all care homes within the borough including care homes with and without nursing and care homes registered to provide care for old age, dementia, mental disorders and learning disabilities. The team is underpinned by a clear philosophy; emphasis is placed upon supporting care homes rather than on inspecting, assigning blame or making judgments about the quality of care. The CHST adopts a holistic approach that aims to address the entire culture of care within the care homes. This involves promoting team work and professional development, underlining the importance of person centred care and encouraging staff to examine existing care practices.

Type of input

Individual 'support plans' are developed at the outset in response to the safeguarding issues and in conjunction with care home managers. The input of the CHST can be divided into four categories: workshops; facilitating access to e-learning, community services and formal training; audits; and managerial support. In the first 12 months of activity the CHST generated guidelines and handouts for workshops covering 16 different topics including person centred care plans, record keeping and understanding dementia. The CHST state that they are not trainers, but aim to provide guidance and facilitate discussion around good practice. Sessions are intended to be as interactive as possible and focus upon the problems and situations that staff encounter in their everyday work.

The CHST also facilitates access to e-learning on Safeguarding Vulnerable Adults (SVA), Mental Capacity Act (MCA) and Deprivation of Liberty (DoL). They signpost to appropriate community services including clinical nurse specialists in palliative care, continence specialist nurses and community dieticians, and formal training including end of life care, support with literacy, and advanced safeguarding vulnerable adults. Thirdly, the CHST have begun to undertake medication audits, which examine how medication is recorded and reviewed in care homes with nursing, and care plan audits, which assess record keeping and the provision of person centred care. This information guides the provision of advice in subsequent workshops and meetings. Finally, managers are provided with extensive face-to-face and telephone support. At the end of the intervention, a 'Manager's Quality Assurance Tool' is devised in conjunction with the manager to support them in sustaining the changes in care practices.

Methods

The aim of this study was to assess the perceived impact of the CHST among care home staff. In-depth individual interviews were used to investigate the attitudes and beliefs of care home staff with different roles and experience. Qualitative methods were considered appropriate given the novelty of the approach and the lack of knowledge in this area (Black & Rabins, 2007). The study used strategies of grounded theory including the simultaneous collection and analysis of data, constant comparison analysis and theoretical memos (Glaser & Strauss, 1967). Research Governance Approval was obtained.

Participants

Invitation letters were sent to managers of the 16 care homes that the CHST had worked with within their first year of activity. Letters included an information sheet, a self addressed envelope and a reply slip to be returned if they did not wish to participate in the study. Managers who did not return the reply slip were given a follow up phone call, at which time further information was given and interviews were scheduled. Following the initial interview, permission was sought to invite care staff to participate in the research. A date was suggested by the researcher, often for the following day, to reduce the likelihood that participating staff would be selected by the manager. Purposive sampling was used to select care staff with a range of characteristics (Patton, 1990), including professional role, length of employment within the care home and within long term care settings. The initial sampling strategy of interviewing one junior and one senior member of care staff within each home yielded theoretical saturation; additional

staff would have been recruited had significant new themes continued to emerge from the analysis of the interviews.

Procedure

Powerful cultures can operate in care homes (Davies & Nolan, 2002) and in-depth interviews provided all participants with the opportunity to express private views and comment upon if and how the culture had changed. Interview guides were derived from a literature review and refined through discussion with an experienced qualitative researcher. The interview began by exploring participant's expectations of the CHST and their concerns or hopes regarding the intervention. The interviewer went on to ask open questions about the specific input of the CHST, including how the CHST presented themselves, how the input was decided and what the input involved. Participants were asked to assess each of these elements and to evaluate the overall impact of the CHST. However, the interview guide was amended iteratively and aimed to follow the participants' priorities and concerns. Data collection became progressively focussed and emerging themes were tested out in subsequent interviews e.g. the importance of ongoing feedback and advice in transferring knowledge into practice. Interviews lasted between 32 and 57 minutes, were conducted within the participants' place of work, were recorded and transcribed verbatim. On each occasion the researcher stressed that it was an independent evaluation of the CHST and *not* of the care home.

Analysis

Data collection and analysis occurred simultaneously from the initial stages of the research. Interview transcripts were scrutinised and emerging themes were identified

and labelled with codes. The constant comparison method was used to delineate similarities and differences between the codes and to develop categories and subcategories, which were verified and refined as the analysis proceeded. Participants with different perspectives were purposefully sought to capture the full complexity of the data. For example, efforts were made to recruit participants with negative experiences of the CHST, often through reiterating to the manager and care staff that the research required a full range of accounts. Theoretical memos were used to record ideas about themes and their relationships, and interpretations and conclusions were regularly discussed in team meetings. The qualitative data analysis software NVivo (QSR International, 2002) was used to manage the transcripts and assisted in coding, organising and retrieving concepts.

Results

A total of 14 managers consented to take part, one care home had closed down, and one manager declined to participate. The characteristics of each care home, the total number of workshops and meetings conducted, and the duration of the intervention are set out in Table I. The CHST had worked with these care homes consecutively over the preceding 12 months, thus a range of time periods had elapsed since their intervention. Seven of the 14 managers had been appointed to the position or had assumed direct responsibility for the care home following the safeguarding incident, five managers had been in post at the time of the safeguarding incident and two managers had self referred to the CHST. Care staff in 13 of the 14 care homes consented to take part in an interview on the agreed date. The sample consisted of five deputy managers, five registered general nurses (RGNs), five senior health care assistants (HCAs) / senior support workers and 10 HCAs / support workers. Table II provides a breakdown of all

workshops and meetings that were conducted across the 14 care homes. The table indicates that certain workshops were repeated and that certain topics required multiple meetings with managers.

Table I

Expectations and concerns

Managers recalled their apprehension about working with the CHST; the majority had been unclear about their role and feared that they would adopt a critical approach. Some managers admitted that they felt defensive at first and that it took time for them to establish trust and interact openly with the team. Some considered this feeling to be even stronger among their staff.

They were really frightened. What are these four people doing here looking at us, it is embarrassing, because they all knew that considering all the problems and all the issues and paper articles, all the staff were really, really, they were not motivated, they were really on the verge of leaving actually...so it took some time. (CP27, Manager)

Staff admitted to having initial concerns, often suspecting that the CHST might “interfere with their work”, or worse still, be “inspectors”, “undercover”, or “spies”. The initial meeting proved critical in putting minds at ease and managers and care staff recalled that the CHST had emphasised their wish for a collaborative approach from the outset. Managers were required to work alongside the CHST in encouraging and reassuring staff and there was awareness that the success of the CHST depended, in part, upon their willingness to cooperate and interact honestly with the team.

We only acted on the things that I told them and if I wasn't open enough then we wouldn't have had that whole period of work being done, it would have been 1-2 weeks and they are gone but because I thought I needed them to see me through the whole process of what I was doing, that's why they kept coming. (CP24, Manager)

Three managers were relatively new to the post and were grateful for the “back up” and that the team provided. Two managers, who had also assumed responsibility for the home following the safeguarding incidents, explained that they would have appreciated more time to put out their own ideas into practice. However, there was evidence that the CHST were willing to adjust the timing of their input when this was discussed.

Table II

Teaching methods

Managers took responsibility for timetabling the workshops so as to minimise the disruption to the home. The aim, which was often achieved with the help of repeat sessions, was for the majority of staff to attend the majority of sessions.

The CHST advised managers not to attend the workshops and most accepted that this would allow staff to interact more freely. However, care was taken to provide minutes and feedback from each workshop, so that managers felt fully informed. The approachability and encouragement of the team frequently led to highly interactive sessions, which care staff described with enthusiasm. There was agreement that all of the sessions had direct practical relevance to their day to day work and many praised the use of (anonymous) examples that the team provided to demonstrate their points.

Staff welcomed the opportunity to discuss problems that they were having within the home, either with particular residents or tasks, or in relation to wider issues such as teamwork. Staff admitted that it took time to transfer theory into practice, but that the ongoing opportunities for discussion facilitated this process.

We learnt information from them, but it is hard for us to, in an instance, it is hard for to us to implement, but later on as we go and take time telling and adjusting to the attitude and behaviour of our residents, and talking to the CHST in particular, yes we gradually applied it. (CP32, Care Assistant)

However, a recurrent issue was that the members of the CHST were not accredited trainers. To an extent this concern seemed rooted in the cost attached to obtaining accredited training courses from other sources. However, managers also suggested that being “proper trainers” and providing staff with recognised certificates would validate the work that the care staff had completed and enhance the credibility of the team.

Strengths of the team

Collaboration

Participants across the professional groups offered consistent and, in many cases, emphatic praise for the CHST. Although it was not always established instantly, relationships with the CHST were typically described as collaborative, and staff shared the view that they were working to achieve a common goal. Care staff were of the opinion that suggestions were generally constructive and focussed upon improving the standard of care. Key to this collaborative approach was the propensity of the CHST to

ask questions, listen to staff, complement existing good practice and praise ongoing achievements. This was epitomised in the interactive nature of the workshops.

It's not one-sided, it's a form of sharing ideas, they listened to what we also say because I can also say that they write something down, when we say something they also write something down (laughs)...I think it motivated me, it motivated us that we are not being taken for granted, they are also taking our ideas on board. (CP39, Deputy Manager)

Participants also acknowledged the flexibility of the team, which not only assisted in organising sessions, but also conveyed their commitment to working around the needs of the home. Ten managers praised the team for the one to one support that they received. The CHST provided valuable encouragement and advice that helped them to feel less isolated in their role.

It made me feel as a manager that you are not on your own because although the providers are quite supportive, sometimes I don't think they always understand, you know you are the manager, especially mine they think I can cope with everything and I suppose to a certain extent you want them to think that you can but you can't always. You know there is some times when you want some support from somewhere so they made it clear that it doesn't matter how big or how small they will support us. (CP03, Manager)

Strengths of the team

Professionalism and expertise

The CHST was frequently praised for their professionalism. Participants commented that they could be relied upon to return calls, keep their appointments and to arrive on time. Staff were impressed that they always responded to queries, even if they did not have the information readily to hand. The CHST was credited with having extensive experience and knowledge about what constituted good practice and the issues surrounding its application. Managers across the sample stated that the objectivity of the team enabled them to identify issues within the home that had previously been overlooked. They also noted that the team were at ease with clients and that their skills were in evidence when they interacted with residents before and after workshops.

Strengths of the team

Interpersonal skills and commitment

There was a strong sense that participants not only respected, but liked, the members of the CHST. The team were routinely described as friendly, warm and having a good sense of humour and this played an important part in putting managers and care staff at ease. Workshops were described as informal and conducive to open discussions. The following quote is typical of the comments made.

Oh they are very pleasant, you feel free, we chat, we laugh, they even ask us to ask questions, which area you didn't understand, they wanted us to ask. They were so good. I really enjoyed it. (CP13, Lead Support Worker)

Notably, every participant commented upon the approachability of the team. Managers and care staff felt comfortable querying suggestions and asking for advice during

scheduled sessions or after the event. The team were also widely praised for their energy, enthusiasm and commitment to the role.

Outcomes

Improved communication between staff

One of the most commonly identified benefits, expressed by seven managers and 10 care staff, was that teamwork was enhanced within the home. The CHST emphasised that working together would enable them to improve the standard of care. Divisions between RGNs and HCAs, night staff and day staff, and care staff within different ethnic groups, were directly addressed and there was a consensus that these relationships had now improved. A frequent observation was that staff had gained an increased awareness of each others roles and responsibilities and now encouraged each other to follow the correct procedures.

I think they probably got together again as teams. I think before it was very much the nurse in charge, telling people what to do but I am now noticing that actually the care assistants are saying this is the way you do it, don't do it that way, so I think that's a great big plus. (CP01, Manager)

However, one member of staff complained that the CHST failed to maintain their impartiality in a session in which he felt personally attacked and two managers questioned the validity of using the workshops as an "forum for complaint".

Outcomes

Staff development and increased confidence

One important benefit of the CHST was that they increased the confidence of the care staff. Ten participants reported that they now felt more knowledgeable and skilled in their role, which boosted confidence and morale.

You feel more competent to perform your work and then the clients get more satisfaction knowing that they are being looked after, they can feel it, so it's good for everybody here. (CP23, Support Worker)

Staff commented that the CHST had played an important part in installing motivation, interest and a sense of pride in their work.

I think it probably made them question a lot and it made them inquisitive and ask questions, which is good. Instead of just coming in to a 9-5 job, coming in and doing the job for the money, I think it gave them a bit of enthusiasm. (CP12, Deputy Manager)

The CHST encouraged all staff to think about delegating responsibilities and assuming additional roles where appropriate. For example, the team advised HCAs to contribute to care plans and deputy managers to assume additional managerial tasks. It was striking that the input of the CHST had permitted certain staff to thrive.

People who have now progressed immensely weren't being allowed to progress because they didn't have, I'm not saying the ability, they maybe didn't have the

experience to be able to challenge staff. So they were kept back quite a bit and kept quiet, you know they weren't driven. And now it's completely swapped round about. I've got a member of staff now who thought her job role when I came here was to make sure the service users had eaten, and that they were clean. Now this girl is running shifts, she's doing key working roles, she'd doing ordering, all sorts. (CP26, Manager)

There was also recognition that some staff had not embraced the training as fully as others. Two managers reflected that established staff members took longer to amend their working methods, while two other managers commented that those who were most opposed to change eventually left the home.

Outcomes

Improved quality of care

Crucially, staff were also of the opinion that residents were happier within the home. Service users with learning disabilities were considered to be more active in the community and managers across the sample reported that aggressive and agitated behaviour had been reduced. Two managers stated that the entire culture within the care home had been transformed, while seven care staff intimated that their attitude towards the residents had changed. Staff explained that they now spent more time talking to residents, getting to know about their lives and focussing care on the individual's preferences and needs. Managers and care staff stressed the importance of devising person centred care plans. Eight participants reported that staff had developed additional skills in working with people with dementia, while six managers identified documentation as a major area of improvement. Care staff explained that they now

provided greater detail in the care notes and managers confirmed that staff displayed greater confidence in this area.

They are caring, but now it's more professional. They can not only talk but now they can write in the records the appropriate language, the appropriate things that they should write, the care notes especially. (CP04, Manager)

Staff agreed that the workshops had enhanced their awareness of good practice and what was expected of them personally and the of care home as a whole.

Sustaining improvements

Participants were asked how easy it was to sustain the improvements that had been made. It was generally considered that the foundations had now been laid, but that maintaining good practice required ongoing energy and commitment.

At the beginning it was a bit of a struggle because people don't like change, nobody likes change, especially with paperwork, nobody likes it but then we had a little, you know meeting also and everybody said we don't want to go back into the past. (CP02, Manager)

Managers acknowledged their role in maintaining standards. This included continuing to encourage care staff, promote training and monitor daily reports, care plans, incident forms, etc. This monitoring was often conducted as part of the 'Managers Audit and Quality Assurance Tool'. This provoked a polarised response: some saw it as a

valuable mechanism for monitoring standards within the home, yet others thought that it replicated existing audits that their organisation required them to complete. Participants reflected that the CHST assisting in maintaining standards by acting as a continued source of information and advice. Others suggested that it would also be helpful for the CHST to return to each care home for a one-off visit. This would act as a “refresher”, provide a forum for discussing any difficulties that had arisen, and validate the achievements that had been made.

Discussion

The data suggests that the CHST is achieving its primary aim of improving the quality of care within care homes in Croydon. Care home staff and managers reported improved communication, skills, motivation, confidence and pride among staff. Evidence of increased competence in tasks such as record keeping and managing clients with challenging behaviour, coexisted with evidence of shifting attitudes and beliefs, with staff reporting that the way that they perceived and interacted with residents had changed. This seemed to reflect the ambitious aims set out by the CHST of changing culture within care homes. This systemic approach, which extended to addressing staff dynamics, staff morale and underlying attitudes towards care, distinguishes it from other training programmes that have focussed on specific care practices e.g. managing depression (Lyne et al., 2006), managing behaviour problems (Proctor et al., 1999). The emphasis placed on meeting the social, mental health and nursing needs of the residents also contrasts with previous interventions that have prioritised mental health or more commonly nursing care (Goodman & Woolley, 2004; Hayes & Martin, 2004; Szczepura et al., 2008). The inclusion of a CPN, district nurse and social worker in the CHST enabled them to work effectively with care homes with and without nursing and

with different categories of care. This represents a useful extension to the literature, which has largely been confined to the provision of care in nursing homes (Szczepura et al., 2008).

The collaborative approach of the CHST was considered to be its greatest strength. The readiness of the team to listen, provide positive feedback, work around the needs of the care home, and not to judge past or present care practices presented as a successful method of engaging care home managers and staff. The ability of the CHST to build positive working relationships with care home managers is paramount given their role in facilitating interventions (Kuske et al., 2007) and affecting cultural change with the home (Deutschman, 2005). The professionalism and expertise, and interpersonal skills and commitment, of the members of the CHST also appeared pivotal to their success. A defining feature of the CHST was its ability to evolve. The team had developed rapidly and the use of certain procedures, such as feedback forms at the end of workshops, assisted them in evaluating and refining their approach. For example, a member of the CHST was in the process of completing a 'Dementia Care Training Programme', which demonstrated awareness of the demand for accredited courses and commitment to the continued development the team.

Given the relative infancy of the service it was not possible to evaluate the effectiveness of the team in sustaining improvements or preventing future safeguarding issues.

However, the opportunities that were provided for ongoing discussion and problem solving have been shown to sustain the implementation of new knowledge in nursing homes (Kuske et al., 2007). Moreover, the success of the CHST in addressing low morale and conflict between staff is promising, given that these factors have been found to be important predictors of abuse (Payne & Fletcher, 2005). Evidence within the field

of learning disabilities suggests that many of the topics addressed by the CHST, including communication, record keeping, personal care and managing challenging behaviours, have important implications for adult protection (White et al., 2003). The CHST encouraged self referrals and hoped to work with an increasing number of care homes on a voluntary basis, thereby decreasingly the likelihood of safeguarding incidents in the future. This is consistent with government guidelines (Department of Health, 2000a) that highlight the imperative of preventing abuse rather than simply reacting to abuse that has already been committed.

However, some caution should be used when interpreting the findings, as although efforts were made to minimise selection bias, it is possible that care staff that participated in an interview were not representative of staff as a whole e.g. it is probably that staff with stronger opinions (either positive or negative) would be more willing to take part. However, there was a striking consistency in responses, despite variation in professional roles and experience, with the vast majority of staff evaluating the CHST positively and citing similar benefits. Furthermore, overall evaluations of the CHST were highly positive among care home managers and in this instance 14 out of a possible 15 were interviewed.

Conclusion

The CHST has developed rapidly since its formation, and this continues. One of the greatest challenges faced was to assuage feelings of apprehension and distrust among managers and care staff. Raising the profile of the team via conferences and newsletters could assist in clarifying their role and generating self-referrals. The data

also underlined the importance of flexibility regarding the timing of the input. While some managers appreciated the backup that the CHST provided, others expressed a wish to implement their own changes before working with the team. Finally, consideration should also be given to adjusting the Manager's Audit Tool to reflect existing auditing practice and to expanding the range of accredited training that they provide. However, in spite of initial apprehensions the CHST emerged as a highly valued service. Reports of improved communication between staff, improved staff development and confidence, and improved quality of care are positive and point towards the effectiveness of the CHST model. The research indicates that the collaborative approach of the CHST underpinned the success of the team and should form the basis of any intervention.

Acknowledgements

We would like to thank all the care home staff who took the time to participate in this research. The study was jointly funded by Croydon Council, Croydon Primary Care Trust and South London & Maudsley NHS Foundation Trust.

References

- Anderson, W. (2004). Specialist support teams: influencing the nursing care of older people. *Nursing Older People*, 16 (1), 18-20.
- Bajekal, M. (2002). *Health Survey for England 2000: characteristics of care homes and their residents*. London: The Stationary Office.
- Ballard, C., O'Brien, J., James, I., Mynt, P., Lana, M., Potkins, D., et al. (2001). Quality of life for people with dementia living in residential and nursing home care: the

- impact of performance on activities of daily living, behavioural and psychological symptoms, language skills, and psychotropic drugs. *International Psychogeriatrics*, 13(1), 93-106.
- Black, B., S., & Rabins, P., V. . (2007). Qualitative research in psychogeriatrics. *International Psychogeriatrics*, 19(2), 167-173.
- Bowham, C., Whistler, J., & Ellerby, M. (2004). A national census of care home residents. *Age and Ageing*, 33(6), 561-566.
- Burgio, L.D., Stevens, A., Burgio, K.L., Roth, D.L., Paul, P., & Gerstle, J. (2002). Teaching and maintaining behavioral management skills in the nursing home. *The Gerontologist*, 42, 487-496.
- Davies, S., & Nolan, M. (2002). Culture of care in care homes in need of further research. *British Journal of Nursing*, 11(2), 78.
- Department of Health. (2000a). *No Secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse*. London: Department of Health.
- Department of Health. (2000b). *Residential personal social services for adults, England*. London: Department of Health.
- Deutschman, M. T. (2005). An ethnographic study of nursing home culture to define organizational realities of culture change. *Journal of Health & Human Services Administration*, 28(2), 246-281.
- Doherty, D. (2008). Examining the impact of a specialist care homes support team. *Nursing Standard*, 23(5), 35-41.
- Glaser, B., G. , & Strauss, A., L. . (1967). *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Chicago: Aldine.

- Goodman, C., & Woolley, R., J. (2004). Older people in care homes and the primary care nursing contribution: a review of relevant research. *Primary Health Care Research and Development*, 5, 211-218.
- Hayes, N., & Martin, F. (2004). Supporting care homes: the older people's specialist nurse. *British Journal of Nursing*, 13(21), 1250-1257.
- Hancock, G. A., Woods, B., Challis, D. & Orrell, M. (2006). The needs of older people with dementia in residential care. *International Journal of Geriatric Psychiatry*, 21, 43-49.
- Kerrison, S., & Pollock, A. (2001). Regulating nursing homes. Caring for older people in the private sector in England. *British Medical Journal*, 323, 566-569.
- Kuske, B., Hanns, S., Luck, T., Matthias, C., Angermeyer, M., C., Behrens, J., et al. (2007). Nursing home staff training in dementia care: a systematic review of evaluated programs. *International Psychogeriatrics*, 19(5), 818-841.
- Lachs, M. S., Williams, C. S., O'Brien, S., Pillemer, K. A., & Charison, M. E. (1998). The mortality of elder mistreatment. *Journal of the American Medical Association*, 280(5).
- Lyne, K., J., Moxon, S., Sinclair, I., Young, P., Kirk, C., & Ellison, S. (2006). Analysis of a care planning intervention for reducing depression in older people in residential care. *Aging & Mental Health*, 10(4), 394-403.
- McCallion, P., Toseland, R. W., Lacey, D., & Banks, S. (1999). Educating nursing assistants to communicate more effectively with nursing homes residents with dementia. *The Gerontologist*, 39, 546-558.
- Patton, M., Q. (1990). *Qualitative Evaluation and Research Methods* Newbury Park: SAGE.
- Payne, B., & Fletcher, L. (2005). Elder abuse in nursing homes: prevention and resolution strategies and barriers. *Journal of Criminal Justice*, 33(119-125).

- Pillemer, K., & Moore, D. W. (1989). Abuse of patients in nursing homes: Findings from a survey of staff. *The Gerontologist*, 19(3), 314-320.
- Proctor, R., Burns, A., Powell, H., Tarrier, N., Faragher, B., Richardson, G., et al. (1999). Behavioural management in nursing and residential homes: a randomised controlled trial. *Lancet*, 354, 26-29.
- QSR International. (2002). NVivo. Victoria, Australia: QSR International Pty Ltd.
- Ronch, J., L. (2004). Changing institutional culture: can we re-value the nursing home? *Journal of Gerontological Social Work*, 43 (1), 61-82.
- Szczepura, A., Nelson, S., & Wild, D. (2008). In-reach specialist nursing teams for residential care homes: uptake of services, impact of care provision and cost-effectiveness. *BMC Health Services Research*, 8(269), 1-15.
- Wang, J. (2006). Psychological abuse and its characteristic correlates among elderly Taiwanese. *Archives of Gerontology and Geriatrics*, 42, 307-318.
- White, C., Holland, E., Marsland, D., & Oakes, P. (2003). The identification of environments and cultures that promote the abuse of people with intellectual disabilities : a review of the literature. *Journal of Applied Research in Intellectual Disabilities*, 16(1), 1-9.
- Wierucka, D., & Goodridge, D. (1996). Vulnerable in a safe place: Institutional elder abuse. *Canadian Journal of Nursing Leadership*, 9(3), 82– 91.

Table I: Characteristics of the care homes and intervention

Index	Type of Service	Care Categories	Total Residents	Duration of intervention (days)	Total workshops	Total meetings (manager)
Home 01	Care home with nursing	Old Age, Alzheimer's/ Dementia	61	164	17	5
Home 02	Care home with nursing	Old Age, Alzheimer's/ Dementia	45	77	9	5
Home 03	Care home only	Learning Disabilities	7	188	8	5
Home 04	Care home only	Learning Disabilities	8	110	7	3
Home 05	Care home only	Learning Disabilities	6	167	7	3
Home 06	Care home only	Old Age, Alzheimer's/ Dementia, Mental Disorder	54	188	9	5
Home 07	Care home only	Learning Disabilities	12	48	5	5
Home 08	Care home only	Old Age, Mental Disorder	11	199	8	6
Home 09	Care home with nursing	Old Age, Alzheimer's/ Dementia, Mental Disorder	60	252	10	9
Home 10	Care home with nursing	Old Age, Alzheimer's/ Dementia	50	154	11	8
Home 11	Care home with nursing	Old Age	19	193	6	6
Home 12	Care home only	Old Age, Alzheimer's/ Dementia	39	136	10	5
Home 13	Care home with nursing	Old Age, Alzheimer's/ Dementia	60	79	8	3
Home 14	Care home only	Old Age	19	111	8	3
Mean	N/A	N/A	32	147	9	5
Range	N/A	N/A	(6,61)	(48,252)	(4,14)	(3,9)

Table II: Total workshop sessions and meetings with care home managers (14 care homes)

	Total number conducted
Workshop topic:	
Safeguarding vulnerable adults	19
Person centred care plans	19
Communication	17
Record keeping	16
Challenging behaviours	16
Understanding dementia	13
Incident reporting	10
Mental Capacity Act	3
Infection control	2
Nurses and midwifery council	2
Nutrition care	1
Activities	1
Skin care	1
Continence care	1
Understanding depression	1
Risk assessments	1
Meeting topic:	
Developing support plan	17
General support	16
Manager's audit and quality assurance tool	15
Introductions	14
Medication / care plan audit	9

